HOUSE . . . . . No. 2761

By Mrs. Teahan of Whitman, petition of Kathleen M. Teahan and others relative to prior approval by the Division of Medical Assistance for certain prescription drug coverage. Health Care Financing.

The Commonwealth of Massachusetts

PETITION OF:

Kathleen M. Teahan	Edward G. Connolly
Michael E. Festa	Elizabeth A. Malia

In the Year Two Thousand and Five.

AN ACT REDUCING LAPSES IN PRESCRIPTION DRUG COVERAGE DUE TO A PRIOR AUTHORIZATION POLICY.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 118E of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting after Section 17 the following sections:—

Section 17A: (1) As used in this section and in section seventeen B and section seventeen C, the following words shall have the following meanings:—

(a) "Prior authorization policy," a policy, which the division institutes, requiring that a recipient receive prior approval in addition to a prescription form, as a condition for receiving full coverage of a prescription drug.

(b) "Review program," a drug utilization review program, created pursuant to the authority of the division, that implements the decision making process of a prior authorization policy.

(c) "Prior authorization request," a submittal, which a review program requires under a prior authorization policy for coverage of a prescription drug.

(d) "Reviewer," a person who, under the authority of the review program, approves or denies a prior authorization request.

(e) "Adverse health effect," a reasonably undesirable reaction to, or side-effect of a prescription drug.

(2) When review program criteria direct a pharmacist to deny coverage of a prescription drug on the basis of a practitioner's failure to submit a prior authorization request to the review program, a reviewer shall:

(a) authorize full coverage of at least a ten day non-refillable supply of the prescription;

(b) immediately contact the prescribing practitioner, and not an intermediary, by telephone;

(c) when the practitioner is available, inform the practitioner of the requirements of the prior authorization policy and how much time the practitioner has to submit a prior authorization request before the recipient experiences a lapse in coverage; and

(d) when the reviewer is unable to contact the practitioner within five days of the first attempt, approve the prescription coverage without requiring a prior authorization request.

Section 17B: (1) When reviewing a prior authorization request, a reviewer shall:

(a) weigh evidence of a reasonable difference in therapeutic value between the prescribed drug and the suggested substitute against the available clinical evidence for that difference;

(b) weigh evidence of individual adverse health effects against the available clinical evidence for those effects; and

(c) when the only conclusive evidence is a lack of clinical evidence; approve the request.

(2) When a reviewer approves a prior authorization request the reviewer shall immediately send a notice of action to the recipient documenting the approval.

(3) When a reviewer denies a prior authorization request, in whole or in part, the reviewer shall:

(a) send a notice of action to the recipient and the recipient's practitioner documenting the denial; and

(b) include in the notice of action:

(i) an express justification documenting why the practitioner's evidence was not sufficient to outweigh the evidence available to the reviewer; and

(ii) a detailed explanation of the process by which the recipient may appeal such action.

Section 17C: (1) The commissioner of medical assistance shall prepare a bi-annual report that evaluates the impact and cost-

effectiveness of the prior authorization policy for each previous six-month period. The commissioner of medical assistance shall:

(a) based on the information contained in the report, formulate and implement a plan of action that will minimize the number of wrongful prior authorization request denials;

(b) include in this report, at a minimum:

(i) a summary of the operation of the prior authorization policy program;

(ii) a reasonable estimate of the cost savings as a result of the prior authorization process;

(iii) the number of prescriptions rejected at the pharmacy, in whole or in part, in the prior sixth month period because a practitioner did not file the required prior authorization;

(iv) the number of prior authorization requests all practitioners filed in the prior six-month period;

(v) the number of prior authorization requests the review program denied in the prior six-month period;

(vi) the number of denied claims appealed by recipients;

(vii) the number of appealed claims subsequently approved; and

(viii) any action that the commissioner of medical assistance is planning to take pursuant to Section 17C(a) of this act.

(2) Three months after the end of a six-month report period, the commissioner of medical assistance shall make this report available for review to the legislature.

Section 17D: Notwithstanding any general or special law to the contrary, prior authorization shall not be required for any anti-hemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders.